U.S. Department of Labor

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Issue Date: 22 May 2006

Case No.: 2005-BLA-06252

In the Matter of

PATRICIA ANN GARNEY
Widow of RAYMOND GARNEY
Claimant

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

George E. Mehalchick, Esquire
For Claimant

Adam F. Welsh, Esquire
For Director

Before: ROBERT D. KAPLAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On July 6, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, the case was assigned to me. The hearing was held before me in Wilkes-Barre, Pennsylvania, on January 9, 2006 where the parties had full opportunity to present evidence and argument. Claimant was granted additional time to submit a supplemental report

[1] The regulations cited are the amended regulations that became effective on January 19, 2001. 20 C.F.R. § 718, et. seq. (2001).

by Dr. Levinson (T 12-13)[2] On February 8, 2006, Claimant submitted Dr. Levinson's supplemental report dated February 7, 2006. This record is herewith received into evidence as CX 2. Claimant did not file a brief. Director filed a brief on March 10, 2006. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

Director conceded that the miner had pneumoconiosis and that it arose out of his coal mine employment. (T 5-6)

The only issue presented for adjudication is whether the miner's death was due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Raymond M. Garney ("the miner") filed a claim for living miner's benefits on numerous occasions and was awarded benefits posthumously on May 20, 2005.

The miner died on November 10, 2004. (DX 4) Claimant filed this claim for survivor's benefits on December 22, 2004. (DX 2) The District Director denied benefits on June 20, 2005. (DX 11) On June 28, 2005, Claimant requested a formal hearing. (DX 12)

B. Factual Background

The miner was born on March 21, 1925. (DX 2) The miner married Claimant on September 14, 1985, and she is his only dependent who is entitled to survivor's benefits under the Act. (DX 2, 3)

Claimant testified that during their marriage she observed the miner frequently having trouble breathing, and this problem got progressively worse. (T 14) The miner was only able to walk the length of two houses or up two stairs due to shortness of breath. (T 14-15) Claimant stated that the miner also experienced problems sleeping and had to sleep in a hospital bed to aid his breathing. The miner was admitted to the hospital on multiple occasions because of his breathing difficulties, the last of which was in October of 2004. (T 15) Claimant was diagnosed with lung cancer, and had lung resection and was treated with radiation and chemotherapy. (T 16, 18) Claimant testified that the miner's breathing problems existed before the diagnosis for lung cancer and continued after treatment for the disease. (T 16-17) The miner also had high blood pressure, chronic obstructive pulmonary disease, two heart attacks, and had angioplasty performed. (T 16, 18)

[2] The following abbreviations are used herein: "CX" refers to Claimant's Exhibits; "DX" refers to Director's Exhibits; and "T" refers to the transcript of the January 9, 2006 hearing.

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. Section 718.205(a) provides that in order to establish entitlement to survivor's benefits under Part 718, Claimant must prove that the miner had pneumoconiosis, that it arose out of his coal mine employment, and that the miner's death was due to pneumoconiosis. Claimant has the burden of establishing each element of entitlement by a preponderance of the evidence. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

D. Relevant Medical Evidence of Record

The miner's medical records show that the miner was admitted to Mercy Hospital on numerous occasions from August 13, 2001 until November 8, 2004. (DX 5) These records will be considered in chronological order.

The first record is a chest X-ray dated August 13, 2001. Dr. Alfred E. Hardaway found no interval changes on the chest X-ray compared to a previous study dated December 14, 2000.

A CT scan of the chest was performed on February 19, 2002 by Dr. Charles Sutton. The physician compared this study to a previous one dated December 19, 2001. Dr. Sutton noted the presence of a nodule in the lingual with a speculated margin and soft tissue extension to the pleural surface and adjacent to the pericardial fat pad, which measured approximately 1.2 cm in size. The physician also noted the presence of a density continuing to the pleural surface and adjacent to the paracardial fat pad, which he opined could represent adjacent atelectasis or consolidation. Dr. Sutton found that the infiltrate in the superior section of the right lower lobe had decreased since the prior examination. The physician noted that there continued to be lymphadenopathy in the mediastinum and some prominence of the left pulmonary hilum. Dr. Sutton stated that malignancy remained the diagnosis of exclusion.

A chest X-ray was taken on April 1, 2002. Dr. Timothy Hou compared this study to a previous one dated December 1, 2001. The physician noted that a suggestion of a 1.5 centimeter nodular density in the region of the lingular lobe was still present. Dr. Hou also noted mild hyperinflation but that no pulmonary infiltrate or effusion was seen. The physician stated that the possibility of a malignancy could not be excluded.

Dr. Peter Andrews provided a History and Physical report dated April 5, 2002. The miner presented with a left lung lesion that was found while he was undergoing a preoperative evaluation for unrelated illness. On physical examination Dr. Andrews found that the miner's lungs were clear without rales, wheezes or rhonchi, and that his heart was regular without murmurs. The physician diagnosed the miner with left lung lesions and admitted him for fiberoptic bronchoscopy, thoracotomy, and lung resection.

Dr. Janusz F. Wolanin performed a consultation on April 9, 2002, and issued a report dated May 15, 2002. The physician noted that the miner had a chest X-ray and CAT scan confirming the presence of a lesion in his left chest area. On physical examination, Dr. Wolanin

found the miner's lungs were clear and his heart was regular with no murmurs, gallops, or rubs. The physician diagnosed left lung upper lobe lesion, history of coronary artery disease, and status post cholecystectony, angioplasty, and hiatal hernia repair.

An arterial blood gas test on April 9, 2002, resulted in a pCO_2 of 47.1 and a pO_2 of 92.2.

A chest X-ray was performed after the miner underwent surgery on April 9, 2002. Dr. Earl Detrick found a drainage tube in the miner's left chest with the tip near the apex. The physician noted that the miner's lung appeared expanded. Dr. Detrick found no definite infiltrates or fluid present and noted that the right lung appeared clear.

A chest X-ray dated April 10, 2002 was reviewed by Dr. Champak Dedhia who compared it to a study dated April 9, 2002. The physician found better inspiration and only minimal atelectasis at the left lung base. Dr. Dedhia noted the absence of pleural effusion and pneumothorax. The physician also noted postoperative changes on the left and that the chest tubes on the left remained unchanged.

Dr. Amita P. Vasoya provided a post-operative management consultation report dated April 10, 2002. The physician noted that the miner had been admitted for elective thoracotomy due to the discovery of a left lung lesion and that he underwent the operative procedure on April 9, 2002, without any perioperative complications. On physical examination Dr. Vasoya found the miner's heart was regular without murmur but his lungs showed bilateral rhonchi. The physician also found mild crepitence in the left thorax where the chest tubes were inserted but noted that the chest tubes were functioning with good respiratory variation. A chest X-ray performed April 9, 2002, showed bilateral subsegmental atelectasis but no evidence of pneumothorax or subcutaneous emphysema. A chest X-ray performed on April 10, 2002, revealed that the chest tube in the hemithorax was in good position and no evidence of pneumothorax, pleural effusion, or infiltrate was noted. Dr. Vasoya diagnosed the miner with status post left thoracotomy and resection of a left lung mass, chronic obstructive pulmonary disease, and history of tobacco dependency.

An arterial blood gas test was performed on April 11, 2002, with a pCO_2 of 42.0 and a pO_2 of 55.7.

A chest X-ray was taken on April 11, 2002. Dr. Detrick compared this study with a previous study dated April 10, 2002. The physician noted that the drainage tube in the left chest was unchanged. The physician also noted minimal atelectatic strands in the left base but found no evidence of a pneumothorax. Dr. Detrick found that the right chest was clear and the mediastinum was unchanged in appearance.

A chest X-ray dated April 12, 2002 was reviewed by Dr. Joseph Rienzi who found interval development of significant subcutaneous emphysema along the miner's left chest wall.

Dr. Bruce Saidman provided a consultation report dated April 12, 2002. The physician noted that the miner's December 2001 chest X-ray and CAT scan showed a lung lesion that was confirmed by later testing as a 1.2 centimeter nodule of the lingual with speculated margin of the

soft tissue extending in to the pleural surface and adjacent to the pericardial fat pad with some adenopathy also noted. The miner underwent bronchoscopy, left thoracotomy, left upper lobe lobectomy, and mediastinal lymph node resection on April 9, 2002. Dr. Saidman reported that pathology revealed the presence of stage 3A adenocarcinoma. The physician diagnosed the miner with stage 3A nonsmall cell carcinoma of the left lung status post resection, history of coronary artery disease, status post angioplasty, history of anthracosilicosis, and history of chronic obstructive pulmonary disease. Dr. Saidman suggested systemic chemotherapy and local radiation therapy as treatment options.

A chest X-ray dated April 13, 2002 was reviewed by Dr. Detrick who compared it to a previous study dated April 12, 2002. The physician found some improvement in the appearance of the miner's left lung, which appeared to have improved aeration. Dr. Detrick noted subcutaneous air was seen again but that no pneumothorax was present.

Dr. Robert Rostock provided a consultation report dated April 14, 2002. The physician noted that he originally saw the miner in mid-February 2002 for bronchitis. Dr. Rostock noted that the miner's chest X-ray and CT scan in December of 2001 showed an abnormality and that the miner underwent surgical resection on April 9, 2002, which revealed a left upper lobe specimen showing adenocarcinoma measuring about 2.3 centimeters and one large peribronchial lymph node and five matted nodes from level 5 in the mediastinum, which were all positive for adenocarcinoma. The physician noted that the miner's past medical history was significant for chronic obstructive pulmonary disease, coronary artery disease with multiple myocardial infarctions, angioplasty, hiatal hernia repair, carpal tunnel release, and laparoscopic cholecystectomy in the past. On physical examination Dr. Rostock found that the miner's lung sounds were distant but clear. The physician diagnosed the miner with T1N2 stage 3A adenocarcinoma of the lung with metastasis to the mediastinum.

A chest X-ray dated April 15, 2002 was reviewed by Dr. Detrick who compared it to a previous one dated April 13, 2002. The physician found no change in the position of the chest tubes. However, Dr. Detrick noted the presence of a small pneumothorax in the miner's left chest, which was not seen on the prior examination. The physician also noted the presence of subcutaneous air, which was present on the last examination.

A chest X-ray was taken on April 17, 2002. The name of the interpreting physician was not included on the report, but this study was compared to a previous study dated April 15, 2002. The physician found a complete resolution of the previously seen small pneumothorax on the miner's left. The physician also noted that the miner's subcutaneous emphysema persisted with no other interval changes found.

A chest X-ray dated April 19, 2002 was reviewed by Dr. Douglas Cutillo who compared it to the film dated April 17, 2002. The physician noted a tiny left apical pneumothorax after chest tubes were removed. Dr. Cutillo also noted a moderate to large amount of subcutaneous emphysema on the left that was without significant change.

A chest X-ray was taken on May 7, 2002. Dr. Sutton noted thickening of the apical pleura but also stated that it could represent fluid. The physician also opined that there may be

atelectasis at the lung bases but that no confluent consolidation was demonstrated. Dr. Sutton found that the left apical pneumothorax and subcutaneous emphysema found on the April 19, 2002 chest X-ray had resolved.

A chest CT scan report dated May 16, 2002 was compared to a previous study dated December 19, 2001. The physician noted postoperative changes of the miner's partial left lung resection and that the nodule seen on the previous examination had been removed. The physician also noted that a moderate size left pleural effusion was present at the left lung base. The physician noted that there were a few scattered normal size nodes through the mediastinum that were unchanged from the previous examination. The physician also noted some nodes along the aortic arch and a node at the left hilum that had resolved since the previous examination. (DX 5, 6

A chest X-ray taken on June 11, 2002 was reviewed by Dr. Hardaway who found no interval changes when compared to the previous study dated May 7, 2002.

A History and Physical report dated June 12, 2002 was authored by L. Ferguson, PA-S. The miner complained of nausea, vomiting, dysphagia, increased weakness, and difficulty swallowing. On physical examination, the physician's assistant found that the miner's heart had a regular rate and rhythm with no murmurs, rubs, or gallops, and his lungs were clear to auscultation without wheezes, rales, or rhonchi. The physician's assistant diagnosed the miner with gastroenteritis, dehydration, status post upper lobectomy, and arteriosclerotic heart disease.

Dr. Paul Niezgoda provided a consultation report dated June 13, 2002. The miner presented with nausea, vomiting, dysphagia, and difficulty swallowing. The physician noted that an upper gastrointestinal series showed tertiary contractions. Dr. Niezgoda noted that the miner's past medical history included coronary artery disease, status post myocardial infarction and angioplasty, histories of phlebitis, coal workers' pneumoconiosis, and carpal tunnel syndrome. On physical examination the physician found that the miner's chest was clear but that he had diminished breath sounds on the left. Dr. Niezgoda diagnosed the miner with nausea and vomiting, which he opined may have had a viral process but also may be an indirect effect of chemotherapy and radiation, dysphagia secondary to radiation therapy, radiation esophagitis, esophageal motility disorder, and history of lung carcinoma.

Dr. Linda Slavoski provided a consultation for leukopenia on June 14, 2002. The miner reported experiencing worsening nausea, vomiting, dysphagia, and diarrhea. The physician noted that the miner had a low normal white blood cell count. Dr. Slavoski also noted that the miner had finished radiation and chemotherapy one week prior. The physician noted that the miner's medical history included coronary artery disease, myocardial infarction, angioplasty, phlebitis, coal workers' pneumoconiosis, carpal tunnel syndrome, cholecystectomy, and left upper lobectomy. On physical examination Dr. Slavoski found the miner's lungs were clear bilaterally and his heart had a regular rate and rhythm. The physician noted that the miner's urinalysis showed moderate epithelial cells. Dr. Slavoski also noted that the miner's chest X-ray was negative. The physician diagnosed the miner with leukopenia and radiation-induced esophagitis but noted that the miner was not neutropenic as shown by his absolute neutrophil count.

A chest X-ray dated July 15, 2002 was reviewed by Dr. Hou who compared it to a film dated June 11, 2002. The physician found mild cardiomegaly and pulmonary congestion. Dr. Hou also found that the opacification of the miner's left lower hemithorax was consistent with a moderate size effusion, which had increased slightly since the previous examination. The physician noted the presence of underlying left basilar infiltrates, atelectasis and suprahilar shadow. Dr. Hou also noted that mild hyperinflation was present. The physician opined that the possibility of a mass or loculated effusion could not be excluded.

A chest X-ray was taken on dated September 20, 2002. Dr. Detrick compared this film to a previous film dated August 28, 2002. The physician opined that there appeared to be an increase in infiltrate in the left suprahilar area and in the right perihilar area. Dr. Detrick also opined that there appeared to be some thickening of the pleura along the miner's left anterior chest.

A History and Physical report by Dr. Wolanin is dated September 25, 2002. The miner presented with increasing shortness of breath and marked dyspnea on exertion. A chest X-ray showed infiltrate in his lung. On physical examination the physician found that the miner's lungs revealed decreased breath sounds bilaterally with wheezing and rhonchi, his heart was somewhat tachycardic, and his heart sounds were distant. Dr. Wolanin stated that pneumonia versus acute bronchospasm and bronchitis must be ruled out as well as further metastatic spread of the miner's lung carcinoma.

Dr. Dineshkumar C. Talati performed a consultation on September 25, 2002. The miner complained of cough, congestion of chest, wheezing, and shortness of breath of two weeks duration. The physician noted that the miner had a history of smoking one pack of cigarettes a day for 40 years but quit 15 years ago. On physical examination Dr. Talati found that the miner's lungs revealed decreased breath sounds in his left chest base with occasional wheeze but no rhonchi, rales, or rubs. The physician noted that the results of an arterial blood gas study showed the miner had a pCO_2 of 31 and a pO_2 of 61. Dr. Talati also noted that the miner's chest X-ray showed increased infiltrate in the left suprahilar as well as the right perihilar area. The physician stated that community acquired pneumonia versus radiation induced pneumonitis must be ruled out. Dr. Talati further diagnosed the miner with chronic obstructive lung disease exacerbation, status post left upper lobe resection for nonsmall cell carcinoma with metastasis to meditation with a stage 3A, history of coronary artery disease, history of myocardial infarction in 1987, history of coronary angioplasty in 1993, status post cholecystectomy, and left vocal cord paralysis and hoarseness of voice.

A chest X-ray taken on September 26, 2002 was reviewed by Dr. Dedhia who compared this film with a film dated July 16, 2002. The physician noted a moderate size infiltrate seen in the perihilar region bilaterally, which he opined most likely represented bilateral pneumonia but further noted that post-radiation changes could not be excluded. Dr. Dedhia suggested a CT scan of the chest to rule out a remote possibility of right hilar mass.

A CT scan of the miner's chest was taken on September 27, 2002. Dr. Rienzi compared the study to a previous study dated May 16, 2002. The physician noted new areas of atelectasis

or infiltrate in the right middle lobe, asygos-esophageal recess, and left upper lobe posteriorly, with the most extensive infiltrate in the left upper lobe. Dr. Rienzi also noted that a moderate left pleural effusion appeared smaller than on the previous study. The physician noted a loculated left pleural effusion anteriorly in the left upper thorax. Dr. Rienzi opined that the findings on the recent chest X-ray might be explained by the infiltrate and effusion rather than being a definite hilar mass.

A chest X-ray dated September 29, 2002 was reviewed by Dr. Scott Sauerwine who noted that the infiltrate in the miner's left upper lobe was unchanged compared to the film dated September 26, 2002. The physician also noted that the right hilum is bulkier compared to previous study dated July 15, 2002. Dr. Sauerwine found blunting of the right costophrenic angle that was compatible with a small amount of pleural thickening or fluid. The physician opined that the infiltrate in the miner's left upper lobe could be pneumonia.

A chest X-ray was taken on September 30, 2002. Dr. Detrick compared this film to a film dated September 29, 2002. The physician found an air fluid level in the right anterior chest superiorly. Dr. Detrick opined that the possibility of a small loculated pneumothorax could not be excluded.

Two chest X-rays are dated November 1 and 4, 2002. The November 1 chest X-ray was reviewed by an unidentified physician who found some improvement in the left hilar area and in the right chest since the previous examination. On the November 4 chest X-ray Dr. Dedhia found no active intrathoracic process and no significant change as compared to the previous study.

The miner again presented to Mercy Hospital on November 5, 2002, with increasing shortness of breath. Dr. Wolanin completed a History and Physical report dated November 5, 2002, and admitted the miner with acute exacerbation of his chronic obstructive lung disease. On physical examination the physician found that the miner's lungs revealed decreased breath sounds in the left base area with wheezing throughout and that his heart was somewhat tachycardic with no audible murmurs, gallops, or rubs. Dr. Wolanin diagnosed the miner with acute exacerbation of chronic lung disease and history of lung carcinoma.

A chest X-ray dated December 17, 2002 was compared with a previous study dated November 4, 2002. The unidentified physician found blunting of the left costophrenic angle that the physician opined could represent either pleural thickening or fluid, which was not present on the previous examination. The physician also found two small densities in the right mid lung zone, which were also not apparent on the previous examination.

The miner presented to Mercy Hospital on January 24, 2003, with progressively worse cough and shortness of breath. Dr. Wolanin issued a History and Physical report dated January 24, 2003. On physical examination the physician found that the miner's lungs revealed wheezing and rhonchi throughout and that his heart was tachycardiac on ambulation. Dr. Wolanin diagnosed the miner with acute exacerbation of chronic obstructive lung disease and history of lung carcinoma.

A chest X-ray was taken on January 24, 2003. Dr. Detrick compared this study with a previous study dated December 17, 2002. The physician found a density along the left anterior chest wall that suggested some pleural thickening. Dr. Detrick also noted postoperative radiation changes in the medial aspect of the left upper chest.

There were two arterial blood gas studies performed on January 25, 2003. On the first study the miner had a pCO_2 of 32.1 and pO_2 of 77.8. On the second study the miner had a pCO_2 of 32.3 and pO_2 of 70.4.

A chest X-ray was taken on January 28, 2003, as the miner had aspirated a small amount of material during a video barium swallow. Dr. James Frangos compared this study to a previous study dated January 24, 2003. The physician noted that there was not a significant collection of barium within the miner's tracheobronchial tree.

Arterial blood gas study results dated February 22, 2003, report a pCO_2 of 28.7 and a pO_2 of 64.9.

Chest X-rays were taken on February 22 and 27, 2003. On the February 22 chest X-ray Dr. Rienzi noted volume loss in the left hemothorax with vascular clips in the left hilum from a previous lobectomy. The physician also noted evidence of interstitial disease without alveolar infiltrates or congestive heart failure. Dr. Rienzi found that the pleural thickening within the left hemithorax was similar to previous studies. On the February 27 chest X-ray the physician found no changes when compared to the February 22 study.

A History and Physical report dated February 27, 2003 was provided by Dr. Wolanin. The miner was admitted to the hospital due to shortness of breath. The physician noted that the miner had been treated with antibiotics and Prednisone as an outpatient for acute exacerbation of his acute bronchitis and chronic obstructive pulmonary disease but that his condition failed to improve. On physical examination Dr. Wolanin found that the miner's lungs were positive for wheezing and rhonchi throughout, especially at the left and right upper lobes, and that his heart was regular but with distant heart sounds because of the wheezing and rhonchi. The physician diagnosed the miner with acute bronchospastic bronchitis, acute exacerbation of chronic obstructive pulmonary disease, history of lung carcinoma, history of swallowing difficulties, history of hyperlipidemia, and history of coronary artery disease.

Dr. Dineshkumar C. Talati provided a consultation report dated February 28, 2003. The physician noted that the miner had been recently hospitalized for acute bronchitis and chronic obstructive pulmonary disease exacerbation. After discharge from the hospital the miner reported developing a cough, congestion in the chest, and expectorating yellow mucus. On physical examination Dr. Talati found that the miner's chest had an increased anterior posterior diameter and his lungs revealed bilateral expiratory wheeze audible on auscultation with a few rhonchi. The physician noted that the miner's chest X-ray from admission showed no changes when compared to a prior film. Dr. Talati diagnosed the miner with acute bronchitis and chronic obstructive lung disease exacerbation, non-small cell carcinoma of the lung status post left upper lobe resection, mediastinal lymphadenopathy, status post medialization of the vocal cords,

history of gastroesophageal reflux disease, coronary artery disease, and history of coronary angioplasty.

A chest X-ray dated March 5, 2003 was reviewed by Dr. Detrick who compared it with a film dated February 27, 2003. The physician found no changes from the previous examination, noting that the density in the miner's left upper lobe medially most likely conformed to post-radiation changes.

A CT scan of the miner's chest was taken on March 5, 2003. Dr. Hardaway compared the study to a previous study dated September 27, 2002. The physician noted that the infiltrate of the left lower lobe superior segment had improved since the last study and that chronic changes remained, which is suggestive of post-radiation fibrosis. Dr. Hardaway also noted that the residual fibrotic changes in the superior segment of the left lower lobe and the infiltrative changes in the right middle lobe and superior segment of the left lower lobe might be secondary to post radiation fibrosis and secondary to radiation therapy. The physician noted a left lower lobe pneumonia with air bronchogram formation and airspace disease. Dr. Hardaway also noted a left-sided pleural effusion. The physician found an area of air bronchograms in the right middle lobe projection, which he opined could indicate changes due to chronic bronchitis or acute pneumonia.

A chest X-ray dated May 19, 2003 was reviewed by Dr. Rienzi who found a soft tissue density in the left hilum and left mediastinum and consolidation in the left upper lobe and superior segment of the miner's left lower lung lobe. The physician recommended CT scanning for follow-up and comparison. Dr. Rienzi found interstitial disease throughout both lungs and pleural thickening in the left hemithorax with volume loss. (DX 5)

The miner presented to the hospital with wheezing and shortness of breath on May 3, 2003. Dr. Wolanin issued a History and Physical report dated May 23, 2003. On physical examination, the physician found the miner's heart had a regular rate and rhythm with no murmurs auscultated. Dr. Wolanin also found that the miner's lungs had coarse breath sounds throughout his left lung lobe and decreased in his left upper lung lobe and right lobe wheezing and rhonchi auscultated throughout especially over the lower lobes. The physician diagnosed the miner with pneumonia, history of lung cancer, history of kidney stones, history of chronic obstructive pulmonary disease, phlebitis, carpal tunnel, and hypertension.

A chest CT scan report dated May 23, 2003 was provided by Dr. Sumblina A. Chaudhary who compared the study to a previous study dated March 5, 2003. The physician noted postsurgical changes in the left hemi-thorax with a decrease of the miner's lung volume, fibrotic change, and traction bronchiectasis involving the left upper lobe and superior segment of the left lower lobe. Dr. Chaudhary also noted a small amount of left sided pleural effusion and increased volume in the right lung with traction bronchiectasis involving the right middle lobe. The physician found no significant mediastinal or perihilar hymphadenopathy.

The miner performed pulmonary function testing on July 29, 2003, with a pre-bronchodilator FEV_1 of 1.73, a FVC of 2.49, a MVV of 84.98, and a FEV_1/FVC ration of 70%. In post-bronchodilator testing the miner had an FEV_1 of 1.79, a FVC of 2.53, and an FEV_1/FVC

ratio of 71%. Dr. Talati opined that the miner had moderate restrictive ventilatory effect as shown by his moderately reduced total lung capacity and associated reduction in his forced vital capacity. The physician also opined that there was the possibility of an obstructive pulmonary impairment because of the miner's reduced FEV_1 and FEV_1/FVC ratio. Dr. Talati found that the miner also had a mild diffusion defect as his diffusing capacity was moderately reduce. The physician also opined that the miner might not benefit from continued bronchodilator therapy as the post-bronchodilator testing failed to demonstrate a significant change in FVC, FEV_1, or FEF 25-75. (DX 6)

A History and Physical report by Dr. Wolanin is dated September 10, 2003. The miner complained of shortness of breath. The physician noted that the miner was initially seen in his office with audible wheezing and exertional dyspena. The miner's wife reported that even with the respiratory treatments administered at home the shortness of breath had become more progressive over the last several days. On physical examination Dr. Wolanin found that the miner's lungs revealed wheezing and rhonchi throughout both lung fields, his heart was somewhat tachycardic, and his heart sounds were somewhat distant. The physician diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease with bronchitis and histories of lung carcinoma, chronic obstructive pulmonary disease, and coronary artery disease.

Dr. Dineshkumar C. Talati provided a consultation report dated September 10, 2003. The miner reported having coughing spells for the last two weeks, mostly in the morning, and wheezing. He had also been expectorating whitish mucous and had chronic postnasal drip. The physician noted that the miner had a smoking history of one pack of cigarettes a day for 40 years but had quit sixteen years ago. On physical examination Dr. Talati found that the miner's chest had an increased anterior posterior diameter and was hyperresonant to percussion bilaterally. The physician also found that the miner's lung fields had decreased breath sounds but were clear with no rales, rhonchi, or rubs noted, and that a minimal wheeze was noted mostly on the left lung. Dr. Talati diagnosed the miner with likely active bronchitis and chronic obstructive pulmonary disease exacerbation, chronic obstructive pulmonary disease secondary to smoking, chronic postnasal drip that may be contributing to his cough, carcinoma of the lung, radiation pulmonary fibrosis in the left upper lung lobe, coronary artery disease, and hypercholesterolemia (DX 5, 6)

A chest X-ray dated September 10, 2003 was reviewed by Dr. Hou who compared it to an X-ray dated March 5, 2003. The physician noted scarring of the miner's left lower hemithorax and that the volume loss in his left hemithorax was unchanged. Dr. Hou also noted hyperinflation consistent with chronic obstructive pulmonary disease and a slight increased opacification of the left lower hemithorax. The physician opined that the possibility of the opacification developing into a small to moderate size left effusion could not be excluded.

The miner underwent arterial blood gas testing on September 10, 2003, with a pCO_2 of 31.3 and a pO_2 of 81.3.

A chest CT scan dated September 13, 2003 was reviewed by Dr. John Iannone who compared this study to a previous study dated May 23, 2003. The physician noted persistent infiltrates in the miner's left upper lobe, which he opined reflected some honeycombing and

chronic interstitial changes. Dr. Iannone found no evidence of an acute alveolar type infiltrate or significant effusion but did note diffuse pleural thickening of the left lung postoperatively. The physician found that the miner's right lung was grossly stable although there were similar focal honeycombing type changes in the anterior aspect of the right upper lobe.

A chest X-ray was performed on December 22, 2003. Dr. Detrick compared the study with a film dated September 10, 2003. The physician noted no acute infiltrates and found that the miner's right lung was clear.

A History and Physical report dated December 23, 2003 was authored by Dr. Wolanin. The miner complained of increasing shortness of breath and reported that he almost fainted after a coughing episode. On physical examination the physician found that the miner's lungs revealed diffuse wheezing and rhonchi throughout and that his heart rate was irregular with premature atrial contractions. Dr. Wolanin diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease and histories of lung carcinoma and coronary artery disease.

The miner presented to the hospital on March 12, 2004 with increasing shortness of breath and dyspnea on exertion. Dr. Wolanin issued a History and Physical report dated March 12, 2004. On physical examination the physician found that the miner's lungs revealed diffuse wheezing and rhonchi throughout especially at the left lung base region, and that his heart was somewhat tachycardiac but without murmurs, gallops, or rubs. Dr. Wolanin diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease with acute bronchitis and a medical history which included lung carcinoma with resection of the left upper lobe, myocardial infaction in the past status post angioplasty, osteoarthritis, and hyperlipidemia.

A chest X-ray dated March 12, 2004 was reviewed by Dr. Hardaway who compared it to films dated September 10, 2003 and December 22, 2003. The physician found no acute pulmonary infiltrates but did find an increased haziness in the miner's left lower lung field that he associated with post-surgical changes. (DX 5, 6)

A chest X-ray was taken on May 7, 2004. The physician who interpreted the study was not named but the study was compared to a previous study dated March 12, 2004. The physician found "no acute intrathora CIC" process and no changes since the previous study.

A History and Physical report dated June 16, 2004 was provided by Dr. Wolanin. The miner complained of shortness of breath and stomach tightness of one week's duration. The physician noted that the miner's medical history was significant for cancer of the left lung, left lung upper lobe resection, and chronic obstructive pulmonary disease. Dr. Wolanin also noted that the miner had a smoking history of smoking one pack of cigarettes a day for thirty years but had quit 20 years ago. The miner reported having a six to eight pound weight gain over the last week and had noticed lower extremity edema as well. On physical examination the physician found that the miner's heart had a regular rate and rhythm without murmurs, rubs, or gallops audible but his lungs revealed decreased left upper region breath sounds with the remaining lung fields showing coarse breath sounds without rhonchi or rales. Dr. Wolanin diagnosed the miner with shortness of breath and chronic obstructive pulmonary disease.

A chest X-ray was taken on June 16, 2004. Dr. Detrick compared this study to a previous study dated May 7, 2004. The physician noted findings consistent with a previous thoracotomy and atelectatic changes in the upper portions of the miner's left lung, which were unchanged from the prior examination. Dr. Detrick also noted that the density in the posterior basal portion of the left chest also remained unchanged. (DX 5)

An arterial blood gas study was performed on June 16, 2004, with a pCO_2 of 35.3 and a pO_2 of 81.5.

A chest X-ray was taken on June 17, 2004. Dr. Hardaway compared this study with a previous study dated September 12, 2003. The physician found interval reduction in the amount of thickening in the left costophrenic angle since the previous study. Dr. Hardaway opined that it might represent resolution of a fluid collection or emphysema. The physician noted evidence of post radiation fibrosis of the left lung associated with post-surgical changes after thoracotomy.

A History and Physical report dated October 28, 2004 was provided by Dr. Wolanin. The miner's wife informed the physician's office that the miner was coughing up a tablespoon of blood and was referred to the emergency room. The physician noted that upon admission the miner was in atrial fibrillation and was admitted to the Progressive Care Unit. Dr. Wolanin noted that the miner's medical history included lung carcinoma, cor-pulmonale, chronic obstructive pulmonary disease due to previous tobacco abuse, hyperlipidemia, and gastric reflux. On physical examination the physician found that the miner's pulse was irregular, his lungs revealed rhonchi and wheezing throughout, and his heart was irregular but without murmurs. Dr. Wolanin diagnosed the miner with hemoptysis with the need to rule out acute exacerbation of chronic obstructive lung disease or further spread of his lung carcinoma and a new onset of atrial fibrillation with the need to rule out "PE" (presumably referring to pulmonary embolism).

Dr. William B. Weiss provided a pulmonary consult report dated October 28, 2004. The physician noted that the miner's medical history included stage 4 nonsmall lung cancer post left upper lobe lobectomy with radiation therapy locally and to the chest for mediastinal lymphadenopathy. Dr. Weiss also noted a subsequent new recurrence of brain metastasis for which the miner was receiving brain radiation therapy. The physician also noted that current chest X-ray was not of good quality but opined that the miner was "perhaps demonstrating some posterior layering left effusion versus chronic pleural changes, a shift of the mediastinum towards the left with a small left thorax consistent with his radiation therapy, some chronic left upper lung field parenchymal changes consistent with the previous CT scan, and a sparse infiltrate at the right base which could be artifact or atelectasis as much as pneumonia." Dr. Weiss also noted a new atrial fibrillation, which he opined was very likely a reflection of the miner's pulmonary events. On physical examination the physician found that the miner's chest had reduced left breath sounds but with good respiratory muscle coordination, no rales, and only mild expiratory prolongation with maintained respiratory muscle coordination. On cardiac examination Dr. Weiss found that the miner's heart showed a systolic ejection murmur and a regular rhythm. The physician diagnosed the miner with hemoptysis with new severe thrombocytopenia. Dr. Weiss opined that both the miner's bronchiectasis and thrombocytopenia, with or without new local recurrence of a tumor, could be responsible for the hemoptysis. The

physician also diagnosed the miner with tracheobronchitis but stated that pneumonitis in the right lower lobe had to be ruled out.

A chest X-ray was taken on October 28, 2004. Dr. Detrick compared this study to a previous study dated June 16, 2004. The physician noted some increased haziness over the miner's left chest as compared to his right and stated that the possibility of some fluid in the miner's left chest should be considered. Dr. Detrick also noted that the miner's right lung showed no acute infiltrates and his mediastinum showed no apparent change.

A chest X-ray dated October 28, 2004 was reviewed by Dr. Rienzi. The physician noted findings consistent with post radiation change in the medial aspect of both of the miner's lungs. The physician found multiple areas of ground glass infiltrate in the right lower lobe and stated that he could not determine whether it represented a neoplasm or other process. Dr. Rienzi also noted the presence of interstitial disease.

Dr. Jose Castillo provided a consultation report dated October 29, 2004. The miner complained of pulmonary congestion and productive cough with sputum that was yellowish to greenish at times. The physician noted that the miner's medical history included left upper lung carcinoma with a left upper lobectomy performed three years ago, recently found metastatic lesions on the miner's brain with whole brain radiation started about two to three weeks ago. On physical examination Dr. Castillo found that the miner's lungs revealed decreased breath sounds at the bases, his heart was irregular, and his extremities showed distal cyanosis but no significant peripheral edema. The physician noted that the miner's chest X-ray showed increased haziness in the left chest with possible effusion. A CT scan of the miner's chest showed the possibility of post radiation changes in both sides of the mediastinum, with multiple areas of ground glass infiltrates in the right lower lobe. Dr. Castillo also noted that the CT scan showed a pleural effusion and a markedly thick wall on the lung segment. The physician diagnosed the miner with acute thrombocytopenia, but stated that ". . .without having previously receiving the past two or three weeks, this may not be true, however one consideration would be whether this might be also associated with current radiation therapy with superimposed myelodysplasia due to previous chemotherapy and radiation. Other considerations would be whether the patient might have a bone marrow replacement by malignancy." Dr. Castillo also noted that HUA syndrome was less likely but could not be excluded.

Dr. Robert Potorski provided a consultation report dated October 29, 2004. The physician noted that upon admission the miner had pancytopenia with a low platelet and a low white blood cell count. The miner also had chronic shortness of breath and atrial fibrillation upon admission. Dr. Potorski noted that the miner's electrocardiogram upon admission showed atrial fibrillation with a moderately fast ventricular rate while the current electrocardiogram showed a sinus rhythm with stable inferior wall pattern. On physical examination the physician found that the miner's lungs revealed a few rhonchi bilaterally with mild expiratory wheezing and his heart showed a soft systolic ejection murmur, but no rubs or gallops were heard. Dr. Potorski diagnosed the miner with a new onset of atrial fibrillation with the need to rule out metastatic lung carcinoma to the pericardium. The physician also diagnosed the miner with known coronary artery disease, lung carcinoma with previous lobectomy in 2002 and now with brain mets with a history of radiation therapy, pancytopenia, chronic obstructive pulmonary

disease, hyperlipidemia, degenerative joint disease, and hemoptysis possibly related to tracheobronchitis and/or current carcinoma. (DX 5)

A chest X-ray dated November 1, 2004 was reviewed by Dr. Cutillo who compared it to films dated June 16, 2004 and October 28, 2004. The physician noted a probable left upper lobectomy with chronic changes and chronic pleural effusion or scarring on the left but noted significant change.

A chest X-ray was taken on November 8, 2004. Dr. Sutton compared this study with a previous study dated November 1, 2004. The physician found increased prominence of the reticulonodular infiltrate in the right mid to lower lung zone. Dr. Sutton noted scarring and upward retraction of the left pulmonary hilum but also noted that the pleural effusion had not changed size significantly since November 1, 2004. The physician also opined that super-imposed congestive heart failure might be present.

The miner's medical records also include an arterial blood gas study dated November 8, 2004, in which the values were pCO_2 of 32.5 and pO_2 of 56.4.

The miner's death certificate states that the miner died on November 10, 2004, due to lung carcinoma and chronic post traumatic stress syndrome. The certificate was completed by Dr. Janusz Wolanin and filed on November 12, 2004. (DX 4)

E. Elements of Entitlement

1. Presence of Pneumoconiosis

The parties stipulated that the miner had pneumoconiosis. I find that the evidence supports this stipulation. Consequently, Claimant has established this element of entitlement.

2. Pneumoconiosis Arising Out of Coal Mine Employment

The parties stipulated that the miner's pneumoconiosis arose out of his coal mine employment. I find that the evidence supports this stipulation. Consequently, Claimant has established this element of entitlement.

3. Death Due to Pneumoconiosis

As this survivor's claim was filed after January 1, 1982, under § 718.1 Claimant must show that the miner's death was due to pneumoconiosis. Death due to pneumoconiosis may be established under § 718.205(c) by any one of the following criteria:

1. Competent medical evidence establishes that pneumoconiosis was the cause of the miner's death.

2. Evidence that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or that death was caused by complications of pneumoconiosis.

3. Under § 718.304, the miner suffered from a chronic dust disease of the lung and chest X-ray evidence shows one or more large opacities (greater than 1 centimeter), biopsy or autopsy shows massive lesions in the lung, or other evidence (in accord with acceptable medical procedures) show a condition which could reasonably be expected to yield such large opacities or massive lesions.

Section 718.205(c)(5) provides that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5). Similarly, the Third Circuit Court of Appeals has held that pneumoconiosis constitutes a "substantially contributing cause" where it shortens life or hastens death, even "briefly." Lukosevicz v. Director, OWCP, 888 F.2d 1001 (3d Cir.1989).[3]

As noted above, the record contains no evidence of large opacities, massive legions, or any other condition which a physician has stated could be expected to result in these. Therefore, § 718.304 is inapplicable here.

The record contains the opinions of the following physicians. [4]

Dr. Sander J. Levinson

Dr. Sander J. Levinson[5] reviewed the miner's medical records and issued reports dated December 14, 2005 and February 7, 2006. The physician credited the miner with 8.5 years coal mine employment and a "substantial smoking history." Dr. Levinson reviewed the miner's medical records from Mercy Hospital, Dr. Talati's medical records, and the miner's death

[3] This case arises in the jurisdiction of the United States Court of Appeals for the Third Circuit because the miner's coal mine employment took place in Pennsylvania.

[4] At the hearing the Director objected to Dr. Levinson's December 14, 2005 report as he relied on evidence that was not in evidence in the instant case. I sustained the Director's objection subject to its renewal by Director, but allowed Claimant additional time to submit a supplemental report by Dr. Levinson. (T 8-13) The Director renewed his objection in his March 10, 2006 brief. However, I have decided to overrule the objection and to admit Dr. Levinson's December 14, 2005 report to the extent that it clarifies his supplemental report dated February 7, 2006, which has already been received in evidence.

Additionally, in his report dated December 26, 2005, Dr. Sherman, who is the Director's expert, also relied on evidence that was not admitted into the record as part of the survivor's claim. However, Claimant did not object to Dr. Sherman's report either at the hearing or in any post-hearing filing. Both Dr. Levinson and Dr. Sherman relied on Dr. Talati's report dated January 18, 2000. Dr. Sherman also relied on Dr. Cali's report dated June 4, 2001, while Dr. Levinson relied on Dr. Talati's report dated May 16, 1996, Dr. Aquilina's report dated June 19, 1996, Dr. Robert Potorski's report dated May 6, 1996, and his own report dated February 12, 2001. Although Dr. Levinson rectified his error in his supplemental report both physicians reviewed and relied on evidence that was not admitted into the record of the survivor's claim. Based on the above and the lack of an objection by the Claimant to Dr. Sherman's report, I find that the Claimant suffers no prejudicial error in considering the entirety of Dr. Sherman's report.

[5] Dr. Levinson's qualifications are not in evidence.

certificate. The physician opined that "pneumoconiosis was a substantially contributing cause and directly hastened the respiratory death of [the miner]." Dr. Levinson noted that the miner's treatment records showed increasing shortness of breath and increasing dyspnea on exertion, including a number of hospital admissions for treatment of his respiratory condition that document his declining oxygenation. The physician also noted that the miner's pulmonary function tests showed a restrictive defect that was unresponsive to bronchodilators, which Dr. Levinson opined is characteristic of pneumoconiosis. The physician also noted that the miner was diagnosed with carcinoma of the left upper lung lobe that was resected in 2002 followed by radiation and chemotherapy. Dr. Levinson explained that the medical records do not indicate that the carcinoma recurred in his lungs although the miner did have subsequent brain metastasis for which he received treatment prior to his death. (CX 1, 2)

Dr. Michael S. Sherman

Dr. Michael S. Sherman (Board-certified in internal and critical care medicine and pulmonary disease) reviewed the miner's medical records and issued a report dated December 26, 2005. The physician credited the miner with 8.5 years of coal mine employment and a cigarette smoking history of 40 pack-years. Dr. Sherman reviewed the miner's medical records from Mercy Hospital, Dr. Talati's report dated January 18, 2000, Dr. Cali's report dated June 4, 2001, a pulmonary function test dated July 29, 2003, Dr. Talati's consultation report dated September 10, 2003, an interpretation of the miner's November 1, 2004 chest X-ray, the miner's death certificate dated November 12, 2004, and Dr. Levinson's report dated December 14, 2005. The physician opined that although the miner was suffering from a pulmonary impairment that was both obstructive and restrictive, his pulmonary impairment was not caused by his pneumoconiosis but by his lung cancer and lung resection. Dr. Sherman explained that the miner's pulmonary function tests prior to his lung resection in April 2002 showed neither an obstruction nor a restrictive pulmonary process. However, after the resection, the miner suffered pulmonary impairment and had numerous hospital admissions for shortness of breath. The physician also noted that the miner suffered further pulmonary injury after his radiation and chemotherapy treatment when he developed radiation injury to his left upper lung with secondary radiation pneumonitis and traction of bronchiectasis. Dr. Levinson opined that the miner's restrictive pulmonary disease was "likely caused by the resection of a portion of his left lung along with the radiation induced fibrosis of the remaining left lung" while the "obstruction and areas of recurrent bronchitis were most likely caused by bronchiectasis due to the radiation, along with hyperinflation of the residual left lung." The physician stated that the exact cause of the miner's death cannot be determined by the medical evidence as the medical records do not contain a discharge summary from the miner's last hospital admission or any progress notes that denote the circumstances surrounding his death. However, Dr. Sherman stated that "it is certainly possible that [the miner] died of respiratory failure given the frequent admissions for respiratory symptoms. However, even if [the miner] died from respiratory failure, the underlying impairment that was causing his respiratory compromise was the result of his pulmonary resection and radiation." The physician concluded by stating the opinion that the miner's "death was secondary to complications of his lung cancer, and that pneumoconiosis did not cause, contribute to, or hasten his death." (DX 18)

I find the opinion of Dr. Sherman to be reasoned and well-documented. A documented opinion is one that sets forth clinical findings, observations, facts, and other data upon which the physician based the diagnosis and conclusions. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). An opinion is reasoned when the underlying data and documentation are adequate to support the physician's conclusions. Fields, supra. Dr. Sherman reviewed the miner's medical records, considered the results of objective testing, and considered the other medical evidence in reaching the conclusion that the miner's death was due to complications from his treatment for lung cancer and lung resection.

Dr. Levinson opined that pneumoconiosis was a substantial factor in the miner's death. In coming to that conclusion the physician reviewed the miner's medical records from Mercy Hospital, Dr. Talati's medical records, and the miner's death certificate. However, the physician seemed to quickly discount the effect of the miner's lung cancer, lung resection, and subsequent radiation and chemotherapy on his pulmonary condition, while the medical treatment records make only brief mention of pneumoconiosis as part of the miner's past medical history. Further, the miner's medical history records repeatedly refer to the effects of the miner's radiation therapy and possible injury to his lungs as a result. Additionally, Dr. Levinson failed to account for the dramatic increase in the miner's pulmonary problems after his lung resection. Based on the above, I find that Dr. Levinson's opinion is neither reasoned nor well-documented. A medical opinion that is undocumented or unreasoned may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989); see also Duke v. Director, OWCP, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis). Consequently, I find that Dr. Levinson's opinion regarding the cause of the miner's death is entitled to little weight.

I note that the medical treatment records show that the miner was treated extensively for lung cancer and related shortness of breath. However, these records do not show that the miner was treated specifically for pneumoconiosis shortly before his death. Additionally, many of the interpreting radiologists and consulting physicians made reference to radiation injury to the miner's lungs because of the chemotherapy and radiation treatment for his lung cancer. Consequently, the miner's medical treatment records do not support a finding that the miner's death was due to pneumoconiosis. Further, the miner's death certificate reports that the miner died due to lung cancer and chronic post traumatic stress syndrome, but not from pneumoconiosis. Consequently, I find that the miner's death certificate does not support a finding that the miner's death was due to pneumoconiosis. Finally, there is conflicting medical opinion evidence regarding whether the cause of the miner's respiratory failure is in any way attributable to pneumoconiosis. I have credited Dr. Sherman's opinion that pneumoconiosis was not a substantial contributor to the miner's death, while I have discounted Dr. Levinson's contrary opinion.

Based on the foregoing, I find that Claimant has failed to establish that the miner's death was due to pneumoconiosis, pursuant to § 718.205(c).

ATTORNEY FEE

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

The survivor's claim of PATRICIA ANN GARNEY for benefits under the Act is DENIED.

A

Robert D. Kaplan
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).